STATE OF CONNECTICUT
TEACHERS' RETIREMENT BOARD
21 GRAND STREET HARTFORD, CT 06106
Toll Free 1-800-504-1102 (860) 241-8414 Fax (860) 525-6018
www.ct.gov/trb

TRB SPONSORED MEDICARE SUPPLEMENTAL INSURANCE INFORMATION

ENROLLMENT REQUIREMENTS

All coverage takes effect on the first day of the month. Enrollment forms must be received by the 25th day of the second month preceding the effective date of coverage. For example, for coverage to be effective March 1, the enrollment form must be received by January 25th. THE FIRST PREMIUM WILL BE DEDUCTED FROM THE FEBRUARY 28TH BENEFIT.

Complete one enrollment form per enrollee. A member and a spouse must each complete a separate enrollment form. Submit proof of Medicare eligibility either by a photocopy of your Medicare Card or a letter from Social Security stating the Medicare Claim# and the effective date of coverage. Once you enroll in a health plan through CTRB, you must remain in that plan until the next open enrollment period of January 2007.

A MARRIAGE LICENSE IS REQUIRED FOR ENROLLING SPOUSES. A CIVIL UNION LICENSE IS REQUIRED FOR ENROLLING CIVIL UNION PARTNERS.

Cancellations

A written cancellation request must be received by the 25th day of the second month preceding the effective termination date. To terminate coverage June 1, notification must be received by April 25th. You will not be allowed to re-enroll in any of the TRB sponsored plans until the next open enrollment period.

Coverage Changes

The dental limit has been increased to $2,000 annually, with full coverage as of the effective date of coverage.

Prescriptions

An annual $250.00 deductible is required for all members of the plan. The Mail Order Co-Pays are 15% for generic, 20% for brand name formulary drugs and 30% for brand name non-formulary drugs. The Retail Pharmacy Co-Pays are 20% for generic, 25% for brand name formulary drugs and 35% for brand name non-formulary drugs. The maximum out of pocket cost is $1,000 per year. When this limit is reached, you will obtain your prescriptions at no charge for the remainder of the year.

Claims/Coverage

Hospital and Medical Coverage are administered by the Board's Claim Administrator, Stirling & Stirling. Prescription Drug Benefits are administered by Paid Prescriptions - Merck-Medco. Dental Benefits are administered through the Delta Dental Plan of New Jersey. For questions regarding enrollment, contact Teachers' Retirement @ 800-504-1102 ext 8414, or 860-241-8400.

When filing claims, please be aware that retirees and spouses enrolled in any of our plans have individual coverage. All claims should be filed as "SELF" with your own social security number regardless of whether you are the retiree or the spouse.

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MEDICARE SUPPLEMENTAL HEALTH INSURANCE ENROLLMENT FORM

Medicare Part A and Part B must be your primary insurance.
Do Not enroll in this plan if you are enrolled in Medicare Part D.

A PHOTOCOPY OF YOUR MEDICARE CARD OR A LETTER FROM SOCIAL SECURITY CONTAINING THE MEDICARE CLAIM # AND EFFECTIVE DATE OF COVERAGE IS REQUIRED.

A MARRIAGE LICENSE IS REQUIRED FOR ENROLLING SPOUSES. A CIVIL UNION LICENSE IS REQUIRED FOR ENROLLING CIVIL UNION PARTNERS.

ONE FORM PER ENROLLEE MUST BE RECEIVED BY THE 25TH OF THE 2ND MONTH PRECEDING THE EFFECTIVE DATE OF COVERAGE.

Once you enroll in a plan, you may not add or drop coverages until the next coverage change period, held each January.

I ELECT TO HAVE THE FOLLOWING COVERAGE BECOME EFFECTIVE _____ /01/ _____

	Cost per person per month	Check one(x)
Medicare Supplement with Prescriptions	$ 83.00	☐
Medicare Supplement with Prescriptions and Dental	$120.50	☐
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	$124.50	☐
Cancel all TRB coverage		☐

ALL ENROLLEES MUST PROVIDE THE FOLLOWING INFORMATION:

Enrollee's Last Name	First	Initial	Home Phone

Street Address	City	State	Zip Code

Social Security Number	Medicare Number	Date of Birth

PREMIUMS ARE DEDUCTED MONTHLY FROM THE MEMBER'S RETIREMENT BENEFIT.

Enrollee's Signature	Date

If you are enrolling as the spouse of a retired teacher, please furnish the following:

Retired Teacher's Name	Social Security Number

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Enrollee's Last Name	First	Initial	Home Phone

Street Address	City	State	Zip Code

Social Security Number	Medicare Number	Date of Birth

PREMIUMS ARE DEDUCTED MONTHLY FROM THE MEMBER'S RETIREMENT BENEFIT.

Enrollee's Signature	Date

If you are enrolling as the spouse of a retired teacher, please furnish the following:

Retired Teacher's Name	Social Security Number